WA State Performance Measures Coordinating Committee (PMCC)

January 22, 2016, 1:00 – 4:00 pm

Meeting Summary

I. Welcome and Introduction:

Ms. Dorothy Teeter, Administrator of the Washington State Health Care Authority, and Nancy Giunto, Executive Director of the Washington Health Alliance, welcomed attendees and thanked them for participating in the meeting. Ms. Teeter reminded everyone of the importance of keeping this a transparent process, allowing for public input and opportunities for participation, sharing all meeting materials and summaries on the Healthier WA website at: http://www.hca.wa.gov/hw/Pages/performance_measures.aspx.

Ms. Giunto reviewed the objectives for the meeting which included: (1) consider and take action on recommendations for necessary modification of existing Common Measure Set; and (2) consider and take action on final recommendations for adding more behavioral health measures to the Common Measure Set.

II. Recommendations: Modification of the Existing Common Measure Set

Susie Dade, Deputy Director of the Washington Health Alliance, provided an overview of the Ad Hoc Workgroup to Review the Existing Common Measure Set. She emphasized that the workgroup was brought together to recommend needed changes to the existing measures and that the review was intended as a "fine-tuning" rather than a comprehensive review. Ms. Dade also noted that representatives on the work group brought tremendous subject matter expertise. Membership (invited) on the ad hoc workgroup included representatives from those organizations involved in producing and submitting results for the first year implementation of the Common Measure Set: Washington State Department of Social and Health Services, Washington State Department of Health, Washington State Health Care Authority, Washington State Hospital Association, Aetna, Cigna, Group Health Cooperative, Premera Blue Cross, Regence Blue Shield, UnitedHealthcare, and the Washington Health Alliance.

Five specific measure recommendations were made to modify the Common Measure Set. All five recommendations were presented and thoroughly discussed before action was taken. Public comment was limited and focused on continued support for use of the "Potentially Avoidable ER Visits" measure. Final action by the PMCC is recorded on page seven of this summary.

RECOMMENDATION #1: ASTHMA – USE OF APPROPRIATE MEDICATION

Currently in Common Measure Set – 2015	Recommendation for 2016
Asthma: Use of Appropriate Medication Measure Steward: NCQA, NQF-Endorsed #0036 Brief Measure Description: Percentage of patients 5-64 years of age who were identified as having persistent asthma and were appropriately prescribed medication during the measurement period. Current Units of Analysis: State, County/ACH, Health Plans, Medical Groups	**Discontinue use of the current measure and replace with the following measure:** **Medication Management for People with Asthma** Measure Steward: NCQA-HEDIS 2016 (MMA), NQF-Endorsed #1799 Brief Measure Description: Percentage of members 5-85 years of age* who were identified as having persistent asthma and were dispensed appropriate medications and they remained on an asthma controller medication for at least 50% of the treatment period. Recommended Units of Analysis: State, County/ACH, Health Plans, Medical Groups **For Medicaid, report only members 5-64 years of age.*

Explanation: The current measure has been retired by NCQA and is no longer part of the NCQA HEDIS Measure Set. This means that NCQA no longer supports the measure specifications and there will be no access to national benchmarks. The recommended measure is part of nationally emerging quality measure sets, such as the Quality Rating System for Exchanges.

NCQA provides the option of reporting results for this measure for different age ranges. The Work Group is recommending that the Common Measure Set report results for "Total – All Ages." Stratifying by age would compound the number of measures and will very likely result in many fewer publicly reportable results, i.e., will not meet the minimum threshold for denominator requirement.

NCQA also provides two options (50% and 75%) for reporting results for "remained on an asthma controller medication for at least X% of the treatment period." The Work Group recommends that we use 50%.

As part of their deliberations, the Work Group also considered a different NCQA measure: Asthma Medication Ratio, NQF-#1800. This is a new measure in 2016. While the Work Group liked this measure, they are not recommending at this time because it is so new.

RECOMMENDATION #2: AMBULATORY SENSITIVE CONDITION HOSPITAL ADMISSIONS FOR COPD OR ASTHMA

Currently in Common Measure Set – 2015	Recommendation for 2016
Ambulatory Sensitive Condition Hospital Admissions for COPD or Asthma Measure Steward: AHRQ, NQF-Endorsed #0275 Brief Measure Description: Admissions with a principal diagnosis of COPD or Asthma per 100,000 population, ages 40 years and older. Excludes obstetric admissions and transfers from other institutions. Current Units of Analysis: State, County/ACH	**Maintain current measure and consider adding one additional measure related to COPD:** Pharmacotherapy Management of COPD Exacerbation Measure Steward: NCQA-HEDIS 2016 (PCE) Brief Measure Description: Percentage of COPD exacerbations for members 40 years of age and older who had an acute inpatient discharge or ED visit and who were dispensed appropriate medications. Units of Analysis: State, County/ACH, Health Plan, Medical Groups

Explanation: The Work Group considered whether to continue the current measure given that the number of admissions is relatively low overall (128 per 100,000 for commercial and Medicaid combined) and when reported per 100,000 the results are difficult for many to understand. Ultimately, the Work Group concluded that, while there are difficulties in reporting and interpreting, the topic is an important one to have reflected in the Common Measure Set.

FYI: The Common Measure Set has two other measures related to COPD or Asthma including Recommendation #1: (1) Medication Management for People with Asthma (NQF #1799), and (2) Use of Spirometry Testing in Assessment and Diagnosis of COPD (NQF #0577).

The Work Group also had a lengthy discussion about whether to recommend adding the PCE measure described above but was unable to reach consensus on a recommendation about whether to add this additional measure.

- Some suggested that it would present an opportunity to analyze whether lower performance on the MMA measure (recommendation #1) and the PCE measure would correlate with higher rates of admission for COPD and Asthma at the county/ACH level.
- There is a strong concern that the number of reportable results at the medical group level, and potentially even at a county level, will be very low.

Note re: the PCE Measure: NCQA provides the option of reporting results for this measure for different age ranges. If selected for the Common Measure Set, the Work Group suggested that results only be reported for "Total – All Ages." Stratifying by age would compound the number of measures and will result in many fewer publicly reportable results, i.e., will not meet the minimum threshold for denominator requirement.

RECOMMENDATION #3: POTENTIALLY AVOIDABLE ER VISITS

Currently in Common Measure Set – 2015	Recommendation for 2016
Potentially Avoidable ER Visits Measure Steward: Medi-Cal Brief Measure Description: Potentially avoidable ER visits, using the Medi-Cal diagnosis list. Current Units of Analysis: State, County/ACH, Medical Group, Hospital	**Maintain current measure (to be updated) and add the following measure:** Emergency Department Visits per 1,000 Measure Steward: NCQA-HEDIS 2016 (AMB) Brief Measure Description: Number of emergency department visits per 1,000 population and is calculated in member years for Commercial data and member months for Medicaid data. Excludes encounters with any of the following: principal diagnosis of mental health or chemical dependency, psychiatry, electroconvulsive therapy, alcohol or drug rehab or detoxification. Recommended Units of Analysis: State, Health Plans

Explanation: Medi-Cal is no longer supporting the current measure. This means that measure specifications are not being updated. However, Group Health Cooperative has generously offered to update this measure for 2016 and to maintain the measure specifications going forward, including translating ICD-9 code in the measure to ICD-10 to enable use of the measure when we are working with 2016 data.

The Work Group acknowledged that ER Utilization continues to be a very important topic for monitoring and that there is strong purchaser interest in this area.

The Work Group explored several options for an additional measure and found the AMB measure (described above) to be the best option. It does not address "*potentially avoidable* ER utilization" specifically, and it excludes behavioral health diagnoses. However, in combination with the continued use of the Potentially Avoidable ER measure we will have more information on this topic.

If the AMB measure is selected for the Common Measure Set, it will be important to be cautious in interpreting results. A significantly lower rate of ER visits per 1,000 may suggest barriers to accessing care, e.g. as a result of high deductibles and/or co-pays. It is worth noting that, compared to national benchmarks, most health plans operating in Washington State currently perform well on this measure so that is a consideration worth taking in to account.

RECOMMENDATION #4: PERCENT OF PATIENTS WITH 5 OR MORE VISITS TO THE ER WITH A CARE GUIDELINE

Currently in Common Measure Set – 2015	Recommendation for 2016
Percent of new patients with 5 or more visits to the ER with a care guideline. Homegrown, Steward: Washington State Hospital Association Brief Measure Description: Percent of newly identified patients with 5 or more visits to the ER who have a care guideline in place. Data comes from the EDIE system. Current Units of Analysis: Hospitals	**Discontinue use of this measure.**
Explanation: The measure only pertains to *newly identified patients* with 5 or more ER visits, i.e., if they have been identified in the past and have a care guideline in place they are not included in the measurement. This makes the results difficult to interpret and understand for the public. The Work Group felt that this is an important measure for the state and hospitals to continue tracking and acknowledges that is very likely to happen because it is tied to Medicaid payment incentives. However, they did not think that it is a meaningful measure for public reporting.	

RECOMMENDATION #5: CARDIOVASCULAR DISEASE – USE OF STATINS

Currently in Common Measure Set – 2015	Recommendation for 2016
Cardiovascular Disease-Use of Statins Measure Steward: ACC/AHA Brief Measure Description: The percentage of patients 18-75 years of age with coronary artery disease who had at least one prescription filled to lower cholesterol (lipid lowering therapy based on current American College of Cardiology guidelines) during a one year period. Current Units of Analysis: State, County/ACH, Medical Groups	**Discontinue use of the current measure and replace with the following measure:** **Statin Therapy for Patients with Cardiovascular Disease** Measure Steward: NCQA-HEDIS 2016 (SPC) Brief Measure Description: Percentage of males 21-75 years of age and females 40-75 years of age during the measurement year who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and met the following criteria: (1) Received statin therapy: Members who were dispensed at least one high or moderate-intensity statin medication. Recommended Units of Analysis: State, County/ACH, Health Plans, Medical Groups
Explanation: The ACC/AHA measure is no longer being updated. Shifting to the NCQA HEDIS measure will permit us to standardize the measure with national measure sets, rely upon NCQA for regularly updating the measure specifications (including current pharmacy), and provide national benchmark data.	

Summary of Action by PMCC:

Recommendation	Action by PMCC	Comment
1. **Remove** measure: Asthma – Use of Appropriate Medication **Substitute/Add**: Medication Management for People with Asthma (NCQA HEDIS, NQF #1799)	**Approved**	NCQA measure good and will provide stability and national benchmark info.
2. **Add measure**: Pharmacotherapy Management of COPD Exacerbation (NCQA HEDIS)	**Rejected**	Significant concerns regarding (1) small N, and (2) lack of recognition of medication already dispensed prior to exacerbation.
3. **Approve GHC as Measure Steward** for "Potentially Avoidable ER Visits" **Add measure**: Emergency Department Visits per 1,000 (NCQA HEDIS)	**Approved**	Strong support for maintaining "Potentially Avoidable ER Visits" measure and appreciation for GHC's willingness to maintain measure. NCQA ED Visits per 1,000 reasonable utilization measure and is associated with system quality/effectiveness. Mixed support for approving this measure to the Common Measure Set.
4. **Remove measure**: Percent of Patients with 5 or More Visits to the ER with a Care Guideline	**Approved**	Agreement that measure is not appropriate for public reporting in Common Measure Set.
5. **Remove measure**: Cardiovascular Disease/Use of Statins (ACC/AHA) **Substitute/Add**: Statin Therapy for Patients with Cardiovascular Disease (NCQA HEDIS)	**Approved**	NCQA measure good and will provide stability and national benchmark info.

III. Recommendations: Behavioral Health Measures

Ms. Dade recapped the process that has been in place to consider the addition of behavioral health measures to the Common Measure Set. An Ad Hoc Workgroup on Behavioral Health Measures met during third quarter 2015 and presented preliminary recommendations to the PMCC at their October 22, 2015 meeting. A public comment period was held in November 2015 and the Workgroup reconvened on December 9 to finalize their recommendations.

Four specific recommendations were made to add Behavioral Health measures to the Common Measure Set. All four recommendations were presented and thoroughly discussed before action was taken. Public comment was limited and focused on general support for adding behavioral health measures. Final action by the PMCC is recorded on page 11 of this summary.

<u>Recommendation #1</u> – Add the following measure to the Common Measure Set: *Follow-up After Discharge from ER for Mental Health, Alcohol or Other Drug Dependence*

Measure Description: The percentage of discharges for patients who had a visit to the ER with a primary diagnosis of mental health or alcohol or other drug dependence (during the measurement period) AND who had a follow-up visit with any provider with a primary diagnosis of mental health, alcohol or other drug dependence within 30 days.

Measure Steward: National Committee for Quality Assurance (NCQA)

NQF-Endorsed: Yes, #2605

Data Required: Claims, including encounter data

Four rates to be reported:

1. Percentage of ER visits for mental health for which the patient received follow-up within 30 days of discharge (ages 6-17)
2. Percentage of ER visits for mental health for which the patient received follow-up within 30 days of discharge (ages 18 and older)
3. Percentage of ER visits for alcohol or other drug dependence for which the patient received follow-up within 30 days of discharge (ages 6-17)
4. Percentage of ER visits for alcohol or other drug dependence for which the patient received follow-up within 30 days of discharge (ages 18 and older)

Recommended Sources of Data for Reporting:

- Commercial Health Plans (for commercially insured lives in the state of Washington)
- Medicaid Managed Care Organizations (for Medicaid insured lives in the state of Washington)

Recommended Units of Analysis:

- Health Plans (Commercial and Medicaid)

<u>Recommendation #2</u> – Add the following measure to the Common Measure Set: *Mental Health Service Penetration (Broad Version to include both behavioral health and medical)*

Measure Description: The percentage of members with a mental health service need who received mental health services during the measurement period.

Measure Steward: Washington State Department of Social and Health Services
Note: This measure is derived from a measure developed by the Washington State Department of Social and Health Services as part of the 5732/1519 performance measure development process. DSHS has agreed to maintain measure specifications over time, including both Medicaid and Commercial Plan versions, and translation of numerator and denominator value sets for ICD-10.

NQF-Endorsed: No

Data Required: Claims, including encounter data

Two rates to be reported:

1. The percentage of members with a mental health service need who received mental health services during the measurement period for ages 6-17.
2. The percentage of members with a mental health service need who received mental health services during the measurement period for ages 18 and older.

Recommended Sources of Data for Reporting:

- Commercial Health Plans (for commercially insured lives in the state of Washington)
- DSHS Research, Data and Analytics (for Medicaid insured lives in the state of Washington)

Recommended Units of Analysis:

- Health Plans (Commercial and Medicaid)
- Counties and Accountable Communities of Health (TBD, if possible)

<u>Recommendation #2</u> (continued) – Add the following measure to the Common Measure Set: ***Substance Use Disorder Service Penetration***

Measure Description: The percentage of members with a substance use disorder service need who received substance use disorder services during the measurement period.

Measure Steward: Washington State Department of Social and Health Services
Note: This measure is derived from a measure developed by the Washington State Department of Social and Health Services as part of the 5732/1519 performance measure development process.

Data Required: Claims, including encounter data

Two rates to be reported:

1. The percentage of members with a substance use disorder service need who received mental health services during the measurement period for ages 6-17.
2. The percentage of members with a substance use disorder health service need who received mental health services during the measurement period for ages 18 and older.

Recommended Sources of Data for Reporting:

- DSHS Research, Data and Analytics (for Medicaid insured lives in the state of Washington)

Recommended Units of Analysis:

- Health Plans (Medicaid only)
- Counties and Accountable Communities of Health (TBD, if possible)

<u>Recommendation #3</u> – Examine data for the following measures in 2016: (1) *Hospital Discharges, Psychiatric Disorders, and (2) Hospital Discharges, Alcohol and Drug Use* (Do not add to Common Measure Set in 2016 for public reporting)

Measure Description: The percentage of patients 18 years and older hospitalized for conditions due to or associated with (1) psychiatric disorders (inclusive of psychotic, mood, anxiety, and personality disorders) and (2) alcohol or drug use. The workgroup recommends that hospital discharges by attributed based on where the patient lives rather than where the hospital is located.

Measure Steward: Washington State Department of Social and Health Services

NQF-Endorsed: No

Data Required: Hospital Discharge Data, CHARS

Recommended Sources of Data for Reporting:

- Washington State Department of Health

Recommended Units of Analysis:

- State
- Counties and Accountable Communities of Health

<u>Recommendation #4</u> – Modify the next Washington Health Alliance's CG-CAHPS patient experience survey to include four questions from the Veteran's Administration Survey of Health Experiences of Patients (SHEP) related to screening and brief alcohol intervention. Results will be publicly reported at a statewide level (not at a medical group level).

Survey Questions Include:

1. How often did you have a drink containing alcohol in the past 12 months? Consider a "drink" to be a can or bottle of beer, a glass of wine, a wine cooler, or one cocktail or a shot of hard liquor (like scotch, gin or vodka). (Please mark only one.)
   Answer Options: Never (If never go to question #___), Monthly or less, 2-4 times a month, 2-3 times a week, 4-5 times a week, 6 or more times a week

2. How many drinks containing alcohol did you have on a typical day when you were drinking in the last year?
   Answer Options: 0 drinks (If 0, Go to question # __), 1-2 drinks, 3-4 drinks, 5-6 drinks, 7-9 drinks, 10 or more

3. How often did you have 6 or more drinks on one occasion in the past 12 months?
Answer Options: Never, Less than monthly, Monthly, Weekly, Daily or almost daily

4. In the past 12 months has a doctor or other health care provider advised you about your drinking (to drink less or not to drink alcohol)?
Answer Options: Yes, No

Summary of Final Action by PMCC:

Recommendation	Action by PMCC	Comment
1. **Add Measure**: Follow-up After Discharge from ER for Mental Health, Alcohol or Other Drug Dependence within 30 days (NCQA, NQF #2605)	**Approved**	Mixed support for approving this measure to the Common Measure Set. Concern that only in-person follow up visits count towards numerator and no national benchmark data available in 2016.
2. **Add Measures**: • Mental Health Service Penetration (Broad Version) • Substance Use Disorder Penetration	**Approved**	Clarify that Mental Health Service Penetration measure is "broad version" meaning that follow-up care provided in medical setting is included in the numerator. This is not true of the Substance Use Disorder measure.
3. Examine data on hospital discharges associated with psychiatric disorders and alcohol or drug use. Consider for future but do not add to Common Measure Set in 2016.	**Approved**	Do not refer to this as a "pilot." This is a special project of the PMCC to better understand hospital discharges associated with behavioral health and to inform future decisions re: the inclusion of associated measures.
4. Request that Washington Health Alliance modify its next CG-CAHPS patient experience survey to include four questions from VA SHEP related to screening and brief alcohol intervention.	**Approved**	

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IV. Next Steps

- A high-level meeting summary will be available within ten days on HCA's website.
- The next PMCC meeting will be held in March or April 2016.

The meeting adjourned at 4:05 pm.

			Attendance on: January 22, 2016	
			Present	Absent
Chris	Barton	SEIU Healthcare 1199NW		X
Craig	Blackmore	Virginia Mason Medical Center		X
Gordon	Bopp	NAMI-Washington (NAMI-WA)		X
Patrick	Bucknum	Columbia Valley Community Health		X
Ann	Christian	Washington Community Mental Health Council		X
Victor	Collymore	Community Health Plan of Washington	X	
Patrick	Connor	National Federation of Independent Business (NFIB)		X
Jessica	Cromer	Amerigroup Washington	X	
Sue	Deitz	National Rural Accountable Care Consortium		X
John	Espinola	Premera Blue Cross	X	
Gary	Franklin	Labor and Industries	X	
Teresa	Fulton	Western Washington Rural Health Collaborative		X
Nancy	Giunto	Washington Health Alliance	X	
Anne	Hirsch	Seattle University		X
Chris	Imhoff	Department of Social and Health Services	X	
Larry	Kessler	UW School of Public Health, Department of Sciences	X	
Byron	Larson	Urban Indian Health Institute		X
Daniel	Lessler	Washington State Health Care Authority	X	
Kathy	Lofy	Washington State Department of Health	X	
Susie	McDonald	Group Health Cooperative	X	
Sheri	Nelson	Association of Washington Business	X - Phone	
Scott	Ramsey	Fred Hutchinson Cancer Research Center		X
Dale	Reisner	Washington State Medical Association (WSMA)	X	
Marguerite	Ro	Public Health - Seattle and King County	X	
Rick	Rubin	OneHealthPort	X	
Torney	Smith	Spokane Regional Health District	X	
Cheryl	Strange	Benefits Trust	X	
Jonathan	Sugarman	Qualis Health	X	
Dorothy	Teeter	Washington State Health Care Authority	X	
Carol	Wagner	Washington State Hospital Association	X	

Additional Meeting Participants (Staff and Work Group Members):

Kathy Bradley, Group Health Cooperative

David Mancuso, Department of Social and Health Services

Susie Dade, Washington Health Alliance

Laura Pennington, WA Health Care Authority

Megan Oczkewicz, WA Health Care Authority